Amt Rec'd:_____

Check/MO:_____

Receipt No.:_____

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH
BUREAU OF LICENSURE AND CERTIFICATION
EMERGENCY MEDICAL SERVICES

NV EMS #:_____

AMBULANCE AND FIRE AGENCY ATTENDANT APPLICATION

This application must be completed and submitted to the State EMS Office, (address listed on back). Please indicate below if this is an initial or a renewal and include the documentation requested for that process.

☐ **Initial Attendant Application**
- **A. Two full sets of fingerprints (forms available at regional offices) and a business check or money order in the amount of $51.25 made payable to Department of Public Safety.**
- **B. A check or money order for $10.00** made payable to: Nevada State Health Division.**
- **C. If in the last 6 months you were a resident of a state other than Nevada, submit a current driving record provided by the Department of Motor Vehicles of that state.**

☐ **Renewal Attendant Application**
- **A. A check or money order for $5.00** made payable to: Nevada State Health Division.**
- **B. If you are a resident of a contiguous state (i.e.: Utah, California, Idaho, Oregon, Arizona) and are working in Nevada, provide a current driving record provided by the Department of Motor Vehicles of that state.**

Name: _____
(Last) (First) (Middle)

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Home Phone: _____ Work Phone _____ Email Address: _____

Type of Attendant: ☐ Volunteer ☐ Paid ☐ Air

Name of Service you intend to be associated with: _____ Permit # _____

1. **PERSONAL INFORMATION:**

S.S. #: _____ D.L. #: _____ State of Issue: _____

Date of Birth: _____ Male ☐ Female ☐

**$25.00 fee on all returned checks

(EMS Office Use Only)

Reviewed by:_____Date:_____ Approve: Ground: ___ Air: ___ Expiration Date: _____

Deny: ___ Reason for Denial:_____

Application complete: ___ DMV printout: ___ Fingerprint Cards w/fee: ___ Valid Certificate: ___ Altitude Physiology (for Air): ___

Date Entered in Database:_____ Date Printed:_____

2. A. Have you, within the last 5 years, been convicted or forfeited bail for a traffic violation other than a parking violation? Yes ☐ No ☐

B. Have you ever been convicted of a felony or misdemeanor other than a traffic violation? Yes ☐ No ☐

C. Have you ever been licensed as a driver, attendant, attendant-driver or air attendant? Yes ☐ No ☐

D. Have you ever had an attendant license or EMS certificate revoked or suspended in any jurisdiction? Yes ☐ No ☐

If your answer to question 2.A.or 2.B. is "YES", explain fully below:

Date	City/State	Violation Give exact nature of all violations	Fine or Disposition of case

If your answer to 2.C. or 2.D. is "YES", explain in full below (attach a separate sheet as necessary):

☐ Additional sheet attached

3. Length of experience in transportation and care of patients: yr. _____ mos. _____

4. (Optional for renewal application) Previous training in transportation and care of patients:

Type of Course (most recent first)	# of hours	Location city-state	Date of Completion

5. (Optional for renewal application) Current and Previous Employment related to EMS:

Employer	Phone number	Location (city, state)	Date of Employment

6. **PHYSICIANS STATEMENT:** (must be dated within last 6 months)

_____is of sound physical and mental health and is free of physical defects or diseases which might impair his/her ability to drive or attend an ambulance, air ambulance, or agency vehicle.

_____ _____ _____

Physicians Signature (Sign in **BLUE** ink) Date License Number

Address:_____

(Street/P.O. Box) (City) (State) (Zip)

All applicants must provide proof of skills retention at the Basic level. In addition, Interemdiate and Advanced EMTs must provide proof of skills retention at their respective levels.

Basic Skills – To be completed by all applicants

Skill	Date	Pass	Fail	Print Evaluator's Name	Evaluator's Signature (Sign in **BLUE** ink)
Mouth to Mask		☐	☐		
Airway Maintenance		☐	☐		
Oxygen Administration		☐	☐		
(Semi) Automatic External Defibrillator		☐	☐		
Patient Assessment		☐	☐		
Bleeding Control / Shock Management		☐	☐		
Immobilization (Bone, Joint, Traction)		☐	☐		
Spinal Immobilization		☐	☐		

Intermediate Skills – To be completed by all Intermediate EMTs

Skill	Date	Pass	Fail	Print Evaluator's Name	Evaluator's Signature (Sign in **BLUE** ink)
Airway EOA/EGTA		☐	☐		
Endotrachael		☐	☐		
Combitube/PTL		☐	☐		
I.V.		☐	☐		
Intra Ossous Infusion		☐	☐		
Medication Administration		☐	☐		

Advanced Skills - To be completed by all Advanced EMTs (Paramedics)

Skill	Date	Pass	Fail	Print Evaluator's Name	Evaluator's Signature (Sign in **BLUE** ink)
1.Ventilatory Management		☐	☐		
2.Cardiac Arrest Management		☐	☐		
3.Cardiac Dysarrythmia Management		☐	☐		
4.Intravenous Infusion		☐	☐		
5.Intraosseous Infusion		☐	☐		
6.Medication Administration		☐	☐		
7.Chest Decompression		☐	☐		
8.NG Tube		☐	☐		

The statement below must be signed by either the course physician of record or a qualified instructor:

I have tested the above-named person for the skills shown.

☐ He/she has been found competent in the administration of these skills to my satisfaction
☐ He/she has **not** been found competent in the administration of these skills to my satisfaction.
☐ I recommend that he/she be re-certified as an EMT.
☐ I recommend that he/she **not** be re-certified as an EMT.

Printed Name of Physician or Qualified Instructor

Signature of Physician or Qualified Instructor (Sign in **BLUE** ink)

7. **CHILD SUPPORT INFORMATION:** (License cannot be issued unless the applicant provides the following information.)

Please check ***one*** of the following:

☐ I am not subject to a court order for the support of a child.

☐ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

8. **SERVICE REVIEW:** (License cannot be issued unless the applicant obtains a signature from both the Service EMS Coordinator and Service Medical Director.)

I have reviewed this application and I approve of the applicant being issued an ambulance attendant license by the Nevada State Health Division.

Service EMS Coordinator: _____ **Date:** _____
Signature (Sign in **BLUE** ink)

Service Medical Director: _____ **Date:** _____
Signature (Sign in **BLUE** ink)

9. **CERTIFICATION OF APPLICANT:**

I hereby certify that all statements made in this application are true and understand that any misstatement of material facts may cause forfeiture on my part of all rights to licensure by the State of Nevada as an ambulance attendant. In addition, I understand that my fingerprints may be forwarded to the Federal Bureau of Investigation as part of the background check conducted by the Health Division and hereby authorize such action by the Health Division.

Applicant: _____ **Date:** _____
Signature (Sign in **BLUE** ink**)**

ANY MISREPRESENTATION OR OMISSION MAY RESULT IN FORFEITURE OR DENIAL OF LICENSE

Nevada State EMS Office
4150 Technology Way, Suite 200
Carson City, NV 89706
(775) 687-7590